SUPPLEMENTARY NOTE TO THE ARTICLE ON "BLINDNESS FOLLOWING INJURIES TO THE BACK OF THE HEAD."*

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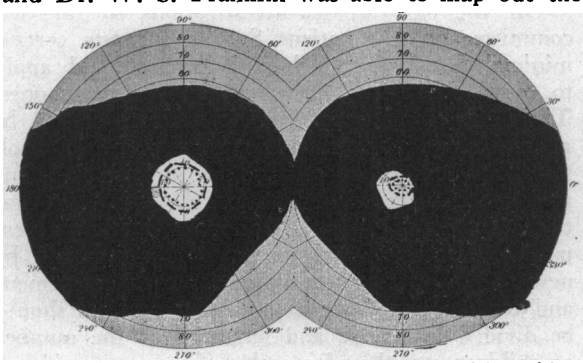
In the paper named in the heading, the prognosis of the blindness which has been observed after injuries to the back of the head was considered, three cases being adduced, one from the literature and two from personal observation. In one of the personal cases the patient was a child, four years of age at the time of the accident. He seemed to be blind for about six months. At the time of the report, a year and eight months after the injury, he could see: "how much, it has not yet been possible to determine accurately, for he can not be induced to fix his gaze with sufficient steadiness to make a perimetric register possible." His central vision was evidently good, but it was thought that the field was greatly constricted.

Since then the boy has grown in understanding, and Dr. W. S. Franklin was able to map out the



fields; the diagrams show them for white, blue and red, in the order mentioned. The optic discs look just as they did in 1914: they are pale, the right paler than the left, but the vessels are not narrow. Central vision is 20/30 in the right eye, 20/20 in the left.

This is the condition four years after the injury.

TWO FREAK ACCIDENTS DURING TONSILLECTOMIES.*

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Case 1. A well-developed boy of 20. An unusually large mouth. He was operated upon for chronic tonsillitis. After finishing the operation on removing the Sewall gag, the patient gasped and the tongue of the gag slipped down his throat, lodging between the cords in the larynx. It gave me a bad half moment but after several attempts was able to grasp it between the tips of my fore and middle finger and bring it to light. There were no after effects.

Case 2. Well-nourished girl of 19, a T. B., who had been built up for a badly needed tonsillectomy. She had never had a pulmonary hemorrhage. She took the anesthetic badly as all T. B.s do. After the uneventful removal of the left tonsil, with the cavity perfectly dry, I shifted the gag preparatory to operate upon the other side, when she gave a cough and her mouth filled up with bright red blood. I sponged rapidly and after a few moments the hemorrhage ceased. In the meanwhile the character of the bright frothy blood had told me what had happened and I quickly enucleated the other tonsil and put the patient to bed. She had one more slight hemorrhage the next morning. Since that time two months after operation she has not had another and her general condition has greatly improved.

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STATUS AND STANDARDS OF DISPENSARY PRACTICE.

It is admittedly true that in the development of the present-day hospital system the growth in size and departments of the out-patient departments has been faster than their growth in efficient methods of practice and administration. There is no doubt that the out-patient department and dispensary have come to stay and that the growing demand for their services will lead to still greater development and extension in the near future. There is reason for believing that the dispensary will come to be one of the chief agents in public health and preventive medicine propaganda. It has been recognized of course as a feeder for the hospital. But equally or even more important is its function in following up post-hospital cases both for treatment and for data on end-results. A specialized feature of dispensary practice is its application to preventive medicine. This is exemplified in the infants' milk stations and children's clinics, the tuberculosis clinics and the social service features which are coming into increasing prominence. The dispensary system is being utilized to good advantage too by industrial concerns both for treatment and for prevention.

In spite of the recognized importance of the dispensary in organized medical work, and of the tremendous impetus in the last few years of the systemization of the hospital system, in the interests of economy and efficiency, the dispensary has been grossly neglected, and its real possibilities and obligations have been slighted. It has remained for the American Hospital Association to institute definite steps toward remedying the present deficiencies. The report of the Committee on Out-patient Service of that association (Read at 16th annual conference of Amer. Hosp. Assoc., at St. Paul., Aug. 25-28, 1914. Reported in *Modern Hospital,* Jan., 1915,) embodies the first available general study of the dispensary situation, and formulates a tentative program for improvement.

The total number of dispensaries in the United States is estimated at 760, of which 400 are general dispensaries, 300 are for tuberculosis only, and 60 are restricted to specialties. Nearly 200 more are devoted to preventive work among babies. There are an indefinite number, too, on a private basis, school clinics, of which most are dental, and commercial clinics, not always ethically conducted. The total of 760 is seven times as great as in 1900. Only ten states have no dispensary at all.

Of the 400 general dispensaries, 75% are in cities of more than 100,000 population; 15% are in cities of between 20,000 and 100,000, and 10% are in towns under 10,000. A significant feature is the recent growth of the dispensary system in the smaller towns and cities.

Of the 400 general dispensaries, about 250, or 62.5%, are out-patient departments of hospitals, and the balance are independent of hospitals. Data could be obtained from but 160 of the 400, and of these 118 were out-patient departments of hospitals. In answer to a question on their organization, 24 of these 118 out-patient departments reported that the clinical medical staff exercised all administrative as well as professional authority. In 11 a clerk or janitor was provided to assign patients and direct employees. In 44 the superintendent of the hospital appointed a representative to discharge these functions. In five of these 44 cases, this representative was changed frequently, and in a large proportion of the remaining 39 the representative is a house officer or nurse with other duties and with no responsibility except for the daily routine. Few indeed had taken the first step toward good organization by placing in charge of the out-patient department a trained officer with due authority. A complicated dispensary receiving several hundred patients daily requires a superintendent in the interest of efficiency and economy just as much as does a hospital. This same criticism holds in effect with the independent dispensaries.

It is stated truly that as a "necessary consequence of inadequate organization, dispensaries have loosely administered admission systems: the routine of transfer of patients for consultation is not worked out: record systems are lax: and perhaps more important than all, the problems and needs of the dispensary are thought out by no one and are not adequately presented to the responsible authorities."

Investigation of dispensary costs was hampered by lack of exact statistics in most cases. A cost accounting system and itemization of different administrative units of the clinic, with a carefully prepared budget, are certainly as necessary in the dispensary as in the hospital or the commercial concern. The unit adopted by the committee of the American Hospital Association was the average cost per patient per visit, but no average figures could be obtained with any reliability. The estimated cost per patient per visit in the out-patient departments ranged from six to sixty-eight cents. The conclusion is drawn that a cost per visit of less than 20 to 25 cents indicates either too low a standard of service or an imperfect system of cost accounting. Fifty to sixty cents can not be considered unjustifiably high. In discussing the cost per visit, as a unit, attention is called to the fact that this unit depends on the two factors of amount of money expended, and the number of visits of patients. With too little money, proper clinical work can not be done. With too many patients for the facilities provided, the standard will also fall.

The report emphasizes the importance of laboratory facilities in the dispensary. Of about 160 institutions answering this question, from 83 to 89% had facilities for examination of urine, blood, sputum, throat and vaginal smears, 67% provided for Wassermann reactions, and 71% for X-ray work. This is an encouraging report, but on turning to the utilization of these facilities by the medical staff, the condition is not found so pleasing. The pertinent query is made, "Are we to be satisfied with medical practice which has a laboratory within its reach, but does not use it?" The remedy is to have an acceptable minimum standard and then to live up to it.

Sixty-eight out of 149 institutions reported a social service department; 68 had none, and 13 did not answer. Stress is justly laid on the percentage of patients paying but one visit even though needing further medical attention. In dispensaries of high standing this percentage is found to vary from 30 to 75%. This represents a large element of waste and inefficiency.

On the basis of its investigations so far, the committee on Out-patient Service suggests certain minimal standards which it believes should apply to most dispensaries, including all the large ones. These are worth repeating. 1. There should be a central administrative authority in control. 2. There should be at least one salaried full-time registrar for clerical and statistical work. 3. Statistics should include the following points: New patients in each department; total visits paid by new and old patients together for each department and for the dispensary as a whole; patients should be divided into male and female with the number of children stated under each. The age considered as childhood should be recorded. 4. There should be a central alphabetical card index giving at least name, age, and address for identification. 5. There should be suitable facilities for isolation of contagious suspects. 6. Every patient in the medical departments should receive a general physical examination as a routine. 7. Laboratory facilities should be provided for at least urine, blood, the simpler bacteriological tests, and for Wassermann reactions. 8. Cystoscopic facilities should be provided in the gynecologic and genito-urinary clinics. 9. An X-ray department is essential. 10. A woman attendant should always be present at the examination of females requiring exposure of the body. 11. There should be some organized social service work. 12. Accounts of out-patient departments should be kept separate from hospital accounts. 13. A system of fees for patients is desirable not only as a financial measure, but for its reaction on the patients, and its stimulus to good administration. 14. A central registry book should be provided for each member of the medical staff to record his hours of arrival and departure at each clinic.

The Committee on Out-patient Service of the American Hospital Association has taken up an important problem and one that has suffered from neglect. The standardization of dispensary and out-patient practice can only be based on thorough studies of present conditions and needs. Such standardization is necessary and the minimal requirements noted above are to be commended.